THE VERMONT BLUEPRINT FOR HEALTH:

The Chronic Care Initiative

STRATEGIC PLAN 2005 – 2010

November 21, 2005

VERMONT
DEPARTMENT OF HEALTH

Dear Vermonters,

Chronic conditions are the leading cause of illness, disability and death, and the most costly for our health care system. In Vermont, over half of all adults have one or more health condition such as heart disease, diabetes or depression that requires ongoing medical care. As the population ages that percentage increases to 68 percent of people age 45 to 64 and 88 percent of people over 65. People with chronic conditions account for 84 percent of health care spending and the vast majority of hospital admissions and physician visits. Yet, studies show that on average people with chronic conditions get the regular care they need only about half the time and too few take the personal action needed to achieve the best outcomes. This does not have to be the case.

Vermont's unique response to this challenge is embodied in the Vermont Blueprint for Health, an expansion of Ed Wagner's innovative chronic care model, designed to effect far-reaching changes in how people define and interact with the health care system. This collaborative project began in the fall of 2003 and is led by a public-private partnership that includes state government, health insurance plans, business and community leaders, health care providers, and consumers.

The attached Strategic Plan sets forth the framework for the next four years to begin the process of transforming the current fragmented approach to service delivery to one that facilitates and encourages coordination and cooperation among multiple stakeholder groups to improve quality of care, quality of life and moderation of cost.

The Vermont Department of Health is proud to be a participant in this groundbreaking endeavor, and I call on all consumers, health care providers, businesses, community members and others, to join us in using this plan to make Vermont a healthier place.

Please feel free to contact me, or any member of the Executive Committee, with your questions and your ideas as we move forward.

Yours truly,

Paul Jarris, MD, MBA
Commissioner of Health

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Executive Summary

The Vermont Blueprint for Health Chronic Care Initiative (Blueprint) was launched in 2003 as a component of Governor James Douglas's package of health care reforms. The Blueprint is led by a unique public-private partnership that includes health care providers, health insurance plans, professional organizations, community and non-profit groups, consumers, businesses, and state government.

Chronic conditions are the leading cause of illness, disability, and death in Vermont. More than half of all Vermont adults have one or more chronic conditions that can be expected to last a year or more, limit what they are able to do, and/or require ongoing medical care. Driven by the combination of an aging population, increased prevalence of obesity, and lifestyle habits such as poor nutrition, physical inactivity, and tobacco use, the needs of Vermonters with chronic conditions will be the primary driver of the demand for health care and the resulting costs for the foreseeable future. The burden of chronic disease is both personal and financial: caring for Vermonters with chronic conditions consumes more than three-quarters of the $2.8 billion spent in Vermont each year on health care.

The Blueprint articulates a clear vision for Vermont: Vermont will have a statewide system of care that improves the lives of individuals with and at risk for chronic conditions. To achieve its vision, the Blueprint will:

1. Utilize the Chronic Care Model as the framework for system change;
2. Utilize a public-private partnership to facilitate and assure sustainability of the new system of care;
3. Facilitate alignment of Blueprint priorities and projects with other statewide health care reform initiatives.

The Blueprint approach calls for fundamental change in the health system at every level to help patients and health care providers effectively manage chronic disease. Innovations in six broad areas will be utilized as part of this effort:

- patient self-management
- provider practice
- community activation and support
- decision support
- information systems
- health system design.

The Blueprint's strategic approach will be implemented on two levels:

1. *Statewide initiatives* to plan and build consensus among stakeholders, identify best practices, build the infrastructure to support a redesigned system of care, and align incentives for sustainability.

2. *Community-focused initiatives* to support changes in approach to chronic care delivery with provider practices, consumer self-management, community activation and support systems, and information technology. Each of these efforts, as well as the synergistic effect of concurrent implementation, will be evaluated at the local Hospital Service Area (HSA) level.

Initial implementation will be carried out through community-based pilots in two Hospital Service Areas (HSAs), Bennington and St. Johnsbury, and will focus on diabetes. As the model is refined, the Blueprint will spread incrementally over five years to include new chronic diseases and to encompass every HSA in the state through staged implementation. The pace of the implementation will be determined by information gained from pilot communities in Year 1 to assure spread of "best practice"; as well as by the availability of funds to support engagement of all HSAs over the next five years.

The Blueprint Executive Committee recognizes that the goals of the Strategic Plan are aggressive and that successful execution of the plan relies on effective statewide and local partnerships, local engagement, and voluntary participation. Subsequently, the Strategic Plan will be reviewed every six months to evaluate progress on goals and objectives and to identify any barriers to implementation. Lessons learned will guide execution, with plan modifications based on assessment.

The Strategic Plan for the Blueprint is the product of a highly collaborative planning effort. It will serve as a guide for operational planning and implementation and as a reference for evaluation for the Blueprint from 2005-2010. The Strategic Plan includes more than 30 measurable objectives to be met in achieving 18 identified goals that are organized by areas of focus.

Goals

A. Overarching goals for the Blueprint

1) The quality of care for Vermonters with chronic conditions will improve.
2) The quality of life for Vermonters with chronic conditions will improve.
3) The cost of caring for Vermonters with chronic conditions will moderate.

B. Replication and spread of the Blueprint

1) By 2010, the Blueprint will be implemented in 75 percent of primary care practices in each HSA.
2) By 2010, the Blueprint will be inclusive of no fewer than four chronic conditions.

C. Overarching goals specific to diabetes

1) The quality of care for individuals with or at risk for diabetes will improve.
2) The quality of life for individuals with diabetes will improve.
3) The cost of health care for individuals with diabetes will moderate as a result of implementing the Blueprint statewide.
4) Access to health care by individuals with diabetes will improve.

D. Provider practice

1) The proportion of patients receiving care consistent with evidence-based standards will increase.

E. Patient self-management

1) Vermonters with chronic conditions will be effective managers of their own health.

F. Community activation and support

1) Vermonters will live in communities that support healthy lifestyles and offer opportunities to prevent and manage chronic conditions.

G. Information technology

1) Vermont will have a Chronic Care Information System (CCIS) that supports statewide implementation of the Blueprint for both individual and population-based care management.

H. Health System Design

1) Vermonters will be served by a health care system that invests in and recognizes quality.

I. Blueprint organizational structure

1) The Blueprint will have an organizational structure that has the capacity to implement and sustain its goals, objectives, and work plans on the statewide and community levels.

J. Effective communication

1) Communication will be effective and timely at all levels of the organizational structure to support planning, implementation, and evaluation of Blueprint goals and objectives.
2) Stakeholders and the public will have a clear understanding of the Blueprint

K. Evaluation

1) A plan for evaluating progress on all aspects of the Blueprint will be in place to guide in measuring progress toward achieving process and outcome objectives at the statewide and community levels.

I. Introduction and Vision

The Vermont Blueprint for Health Chronic Care Initiative was launched in the Fall of 2003, as a component of Governor James Douglas's package of health care reforms. It is built on the premise that improving the quality of care for people with chronic illness is an effective way to reduce the overall demand for the highest-cost treatment services.

The Vermont Blueprint for Health (Blueprint) has been widely supported. The FY2005 budget as passed by Vermont General Assembly and signed by Governor Douglas included an initial appropriation for the Blueprint; the appropriation grew to $1.04 million in the FY2006 budget. In addition, every health care reform bill introduced during the 2005 legislative session included a component addressing funding for the Blueprint. The Blueprint has been praised throughout the state and among national leaders for its comprehensive, collaborative, and innovative vision.

The Vermont Blueprint for Health articulates a clear vision for Vermont:

> **Vermont will have a statewide system of care that improves the lives of individuals with and at risk for chronic conditions.**

To achieve its vision, the Blueprint will:

1. Utilize the Chronic Care Model as the framework for system change;
2. Utilize a public-private partnership to facilitate and assure sustainability of the new system of care; and
3. Facilitate alignment of Blueprint priorities and projects with other statewide health care reform initiatives.

This Strategic Plan provides a road map for implementing, evaluating, and sustaining the Blueprint from 2005-2010.

II. The Burden of Chronic Illness

More than half of all Vermont adults have one or more chronic conditions.[1] Chronic conditions are defined as chronic illnesses and impairments that are expected to last a year or more, limit what the individual is able to do, and/or require ongoing medical care. Chronic conditions include diabetes, hypertension (high blood pressure), cardiovascular disease, asthma, respiratory diseases, substance abuse, psychiatric illnesses, and hyperlipidemia (high cholesterol), among other conditions.

[1] Vermont Department of Health. *Behavioral Risk Factor Surveillance Survey (BRFSS),* 2003.

Chronic conditions are the leading cause of illness, disability,[2] and death in Vermont. The number of Vermont adults reporting chronic conditions increases with age: in a recent survey, 88 percent of Vermonters age 65 and older reported having one or more chronic conditions and 20 percent reported having four or more.[3]

The U.S. population with chronic conditions is projected to increase by more than one percent per year through 2030.[4] The increase is driven by a combination of an aging population, increased prevalence of obesity, and lifestyle habits such as poor nutrition, physical inactivity, and tobacco use. Increased prevalence of obesity is of particular concern as it is associated with development of most chronic conditions and complicates treatment of all chronic conditions. In Vermont, the rate of overweight and obesity[5] is increasing among all population groups. In Vermont in 2003, 54.3 percent of adults over the age of 20 were overweight (35.2 percent) or obese (19.1 percent) compared to 46.9 percent in 1993, an increase of nearly 0.7 percent per year. More troubling are increases in overweight among youth in grades 8 through 12 of about 0.5 percent per year, and among 2-5 year old children on WIC by about 0.4 percent per year.

Overweight and obesity are the result of too many calories consumed and too few calories expended. There is little data on calorie intake of Vermonters, but the trend in the US indicates an increase of 530 calories per day or 24.5 percent between 1970 and 2000.[6] This increase has been fueled by larger portion sizes of most foods, more sweetened beverages, and higher fat snack foods. In Vermont in 2003, 45 percent of adults and 26 percent of youth (grades 8-12) reported that they did not participate in moderate physical activity at least five days per week.[7]

The burden of chronic disease is not only personal but financial. Chronic conditions are the primary reason people receive health care. As a result, caring for Vermonters with chronic conditions consumes more than three-quarters of the $2.8 billion spent in the state each year on health care.[8] Nationally, care for people with chronic conditions represents 83 percent of health care spending, 81 percent of hospital admissions, 76 percent of all physician visits, and 91 percent of prescriptions written.[9]

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[2] At least 25% of Vermonters with chronic conditions have limitations that restrict normal activities. Estimate based on national prevalence data cited in *Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update*, a chartbook published by Partnership for Solutions: Johns Hopkins University and the Robert Wood Johnson Foundation (www.partnershipforsolutions.com).

[3] *BRFSS*, 2003.

[4] *Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update.*

[5] Overweight is defined as a BMI of 25 to 30 and obesity as a BMI greater than 30.

[6] USDA Economic Research Service. http://www.usda.gov/factbook/chapter2.htm

[7] *BRFSS*, 2003.

[8] It is estimated that in excess of $2.3 billion was spent on chronic conditions in Vermont in 2002, including approximately $407 million in Medicaid spending. *Vermont Health Care Expenditure Analysis 2002.* Vermont Dept. of Banking, Insurance, Securities, and Health Care Administration.

[9] Medical Expenditure Panel Survey, 2001, cited in *Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update.*

A 2004 RAND Corporation report on the quality of health care in the United States found the quality of care received by people with chronic conditions to be inadequate approximately half of the time.[10] Such inadequate care has an adverse impact on both health care costs and on quality of life for individuals who have or are at risk for chronic diseases.

The needs of Vermonters with chronic conditions will be the primary driver of the demand for health care and the resulting costs for the foreseeable future. As "baby boomers" age, the impact of chronic conditions will continue to grow. As it grows, the imperative to improve the quality of life for those who experience chronic conditions and to contain costs will become even more pressing.

The current health care system in Vermont and in the nation has evolved to provide care for people with short-term, acute, and episodic health needs. However, unlike acute or episodic care, prevention and management of chronic disease requires proactive, planned care and an ongoing, productive relationship between the patient and the provider team. Because so much of chronic care involves self-care, the locus of control for people with chronic conditions must lie with the individual with support from the family, provider, and community.

III. Vermont's Response

The Vermont Blueprint for Health is Vermont's response to the challenge presented by chronic conditions.

The Blueprint approach calls for fundamental change in the health system at every level to help patients and providers effectively manage chronic disease. Using the Chronic Care Model as the framework for system change, innovations in six broad areas will be utilized as part of this effort:

- patient self-management
- provider practice
- community activation and support
- decision support
- information systems
- health system design.

The Chronic Care Model is a national model for collaborative care and quality improvement that encourages patients, providers, the community, and insurers to work in concert rather than in isolation. (*See* Figure 1) The Chronic Care Model was developed as an illustration of the components necessary to improve care for people for chronic diseases within a health care setting, while the Blueprint expands this approach to include a larger community of stakeholders. The model illustrates four critical spheres of

[10] McGlynn, EA, Asch SM, Adams J, Keesy J, Hicks J, DeCristofaro, A, Kerr EA. *The Quality of Health Care Delivered to Adults in the United States.* NEJM 2003 348:26.

influence and how they must work in collaboration to achieve improved health outcomes: patients, practice team, health system/health care organization, and community.

The effectiveness of the Chronic Care Model is predicated upon multiple elements of the model functioning *in combination*. To enable the unprecedented degree of collaboration at all levels that will be required for the initiative to succeed and be sustainable in Vermont, the Blueprint is led by a unique public-private partnership that includes health care providers, health insurance plans, professional organizations, community and non-profit groups, consumers, businesses, and state government. More than 80 individuals have been actively involved in planning for the Blueprint through their involvement on various committees and work groups to date. (*See* Appendices.)

The Blueprint will build upon the experience gained from the implementation of several Vermont-based initiatives.

- Chronic Care Collaboratives, led by the Vermont Program for Quality in Health Care (VPQHC), train and support individual primary care practice teams to improve the quality of diabetes and cardiac care using the Chronic Care Model and the Model for Improvement promoted by the Institute for Health Improvement (IHI).
- The Community Depression Project, a project of the Office of Vermont Health Access (OVHA, i.e., Vermont Medicaid Program) uses a collaborative treatment model that integrates the physical and psychological factors that affect depression as well as other chronic conditions.
- OVHA's Medical Home Project uses the Chronic Care Model to address primary care for individuals with severe and chronic mental illness.
- The Vermont Child Health Improvement Program (VCHIP) runs collaboratives using the Chronic Care Model that address care of children with special health needs as well as children's preventive services and prenatal care.
- Dartmouth College offers training in clinical microsystem development, a process improvement program for provider practices.
- The Northeast Healthcare Quality Foundation uses practice improvement strategies to improve care for people with a variety of clinical conditions.

The Blueprint is the nation's first public-private initiative working on the statewide level to change the way health care is delivered for chronic conditions. Other efforts to improve chronic illness care have been limited to individual practices, single health maintenance organizations, or consortia of businesses.

The Blueprint strategic planning process was a highly collaborative effort that drew upon the expertise of stakeholders representing many disciplines and points of view. Work group members devoted many hours to the planning process on a volunteer basis. Co-Leaders were chosen to guide each work group with support from the Blueprint's Executive Director, Steering Committee, and consultants.

This strategic plan document will serve as a guide for operational planning and implementation and as a reference for evaluation for the Blueprint for the next five years. Broad-based support for the Blueprint's vision, goals, objectives, and strategies is demonstrated by unanimous adoption of the strategic plan by the eight partner agencies and organizations, both public and private, that comprise the Blueprint's Executive Committee.

IV. Organizational Structure

An undertaking as complex as the Blueprint will require a sturdy, well-defined organizational structure. To accomplish an ambitious planning effort in a short time frame, a multi-level interim organizational structure was put in place that includes an Executive Committee; a larger, advisory Steering Committee; four component-specific work groups; and planning teams in the two pilot communities. The planning effort was directed and staffed by the Executive Director, who is an employee of the Department of Health, with additional support from other key Health Department employees. Consultants were engaged to assist with specific tasks.

As part of the strategic planning process, the Executive Committee assessed the effectiveness of the existing governance structure based on the project's recent history as well as anticipated needs and potential tensions as the initiative moves into the implementation phase. Based on the assessment, the Committee clarified roles, responsibilities, and decision-making and reporting authority.

To succeed, the Blueprint also requires an organizational structure that has the capacity to execute the plan for achieving its goals. Beyond the Executive Director role, this operational capability has yet to be fully developed. The strategic plan includes a goal directed at further developing this capacity. In the interim, the operational capacity of the Department of Health will be utilized.

The components of the current organizational structure are:

Governance Structure

A. Executive Committee

The Executive Committee provides leadership and helps set the vision, direction, and priorities for the Blueprint, in tandem with the Commissioner of Health. The Executive Committee has decision-making authority for the public-private partnership, provided they are consistent with state law, and policies of the Executive Committee's constituent organizations. The Committee is chaired by the Commissioner of Health and elects a Vice Chair from a private partner organization. It is composed of designated individuals from partner organizations that are key stakeholders for effective system change. New members may be added by vote of the Committee when

indicated. The Committee currently is composed of designated individuals representing the following key stakeholder groups:

- Blue Cross and Blue Shield of Vermont
- MVP Health Care
- Office of Vermont Health Access/Medicaid (OVHA)
- Vermont Association of Hospitals and Health Systems (VAHHS)
- Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA)
- Vermont Department of Health (VDH)
- Vermont Medical Society
- Vermont Program for Quality in Health Care (VPQHC).

B. Steering Committee

The Steering Committee serves as a statewide advisory body to the Blueprint Executive Committee and staff. Its role is to advise on and assist in the development and implementation of priorities for the Blueprint. It comprises members of the Executive Committee, a co-chair from each of the workgroups, consumer representatives, and representatives from public and private organizations critical to the successful implementation of the Blueprint strategic plan.

Operational Structure

A. Executive Director

The Executive Director is responsible for execution of implementation strategies, operating plans, and policies for the Blueprint, as approved by the Executive Committee. The role includes oversight of planning and implementation activities with statewide partners and other stakeholders to assure that the Blueprint's goals and objectives are met; developing and managing the operating budget; identifying and seeking funding opportunities; coordinating grants and contracts which support implementation activities; and assuring timely communication with partners, stakeholders, and the public.

B. Work Groups

Work group members play a key role in planning and evaluation in their areas of expertise. Work group membership includes partner organizations and key stakeholders, including non-profit and for-profit service providers and consumer advocates. Work group co-leaders provide expert consultation and guide the workgroup process.

C. Communities/Hospital Service Areas

Local leadership teams in pilot Hospital Service Areas (HSAs) mirror the statewide workgroups and serve as the vehicle for implementation of the Blueprint strategy on the local community level. The local teams of stakeholders in the communities carry out planning and implementation efforts consistent with the Blueprint strategy and which are financially supported by the Blueprint.

D. Staffing

Several positions within the Department of Health have been approved to support execution of plans. The organizational structure to manage these functions is currently under development.

V. The Strategic Approach

A. The Chronic Care Model

The Chronic Care Model provides the framework for the Blueprint. The Chronic Care Model was developed by Improving Chronic Illness Care (ICIC), a national program of the Robert Wood Johnson Foundation.[11]

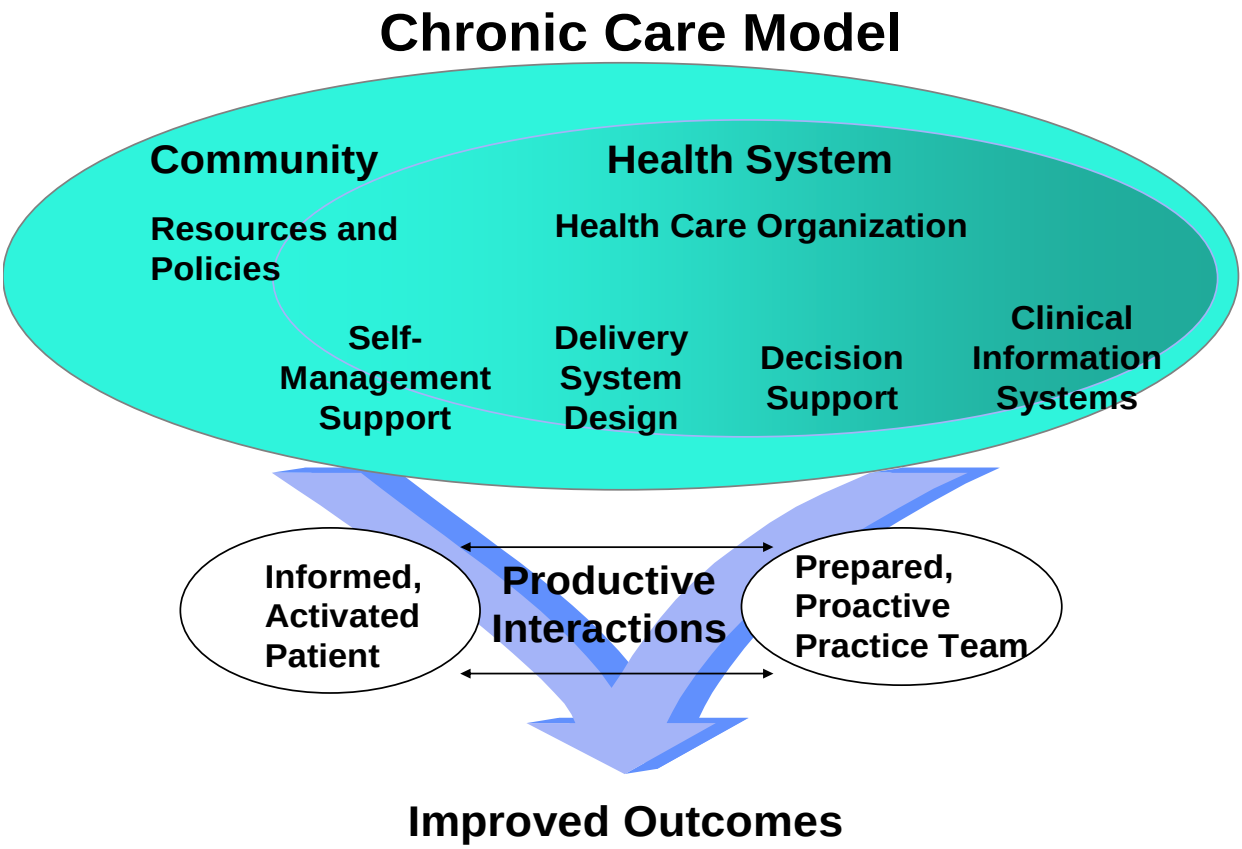
Based on an analysis of available literature about promising strategies for chronic illness management, the Chronic Care Model envisions:

- an informed, activated patient who interacts with...
- a prepared, proactive practice team...
- resulting in
- high quality encounters in health care settings, and
- improved functional and clinical health outcomes.

The premise of the Chronic Care Model is that all components of the model should be in place simultaneously to achieve improved health outcomes. Although the model was developed specifically for improving care in managed care settings, it has wide applicability to any type of planned care including preventive services, and can be applied to management of all chronic conditions, health care settings, and target populations.

[11] ICIC is a national program of The Robert Wood Johnson Foundation with direction and technical assistance provided by the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Seattle. www.improvingchroniccare.org

Figure 1 Chronic Care Model[12]



[12] Used by permission of "Effective Clinical Practice." (Original publication: Wagner, E.H. *Chronic Disease Management: What will it take to improve care for chronic illness?* Effective Clinical Practice 1998; 1:2-4.)

Predictive modeling provides theoretical support for the moderation of costs and significant improvements in clinical and functional status for individuals with chronic conditions that can be achieved when multiple elements of the Chronic Care Model are in place. Figures 2, 3, and 4 look at improvements in the morbidity, mortality, and cost of diabetes based on several scenarios, comparing improvements that may be achieved when elements are implemented singly and in combination.[13] They predict that a significant decrease in the curve will occur when the multiple elements of the Chronic Care Model—in this example, better care and obesity prevention--work in combination.

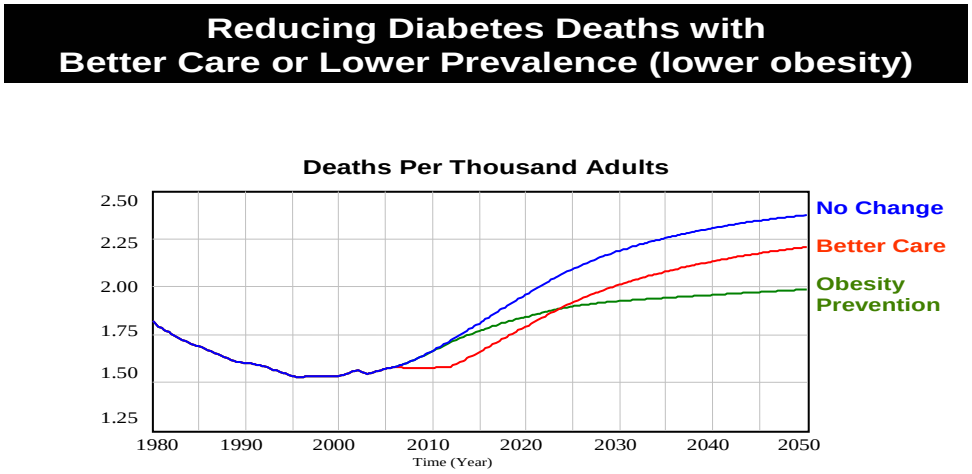


Figure 2

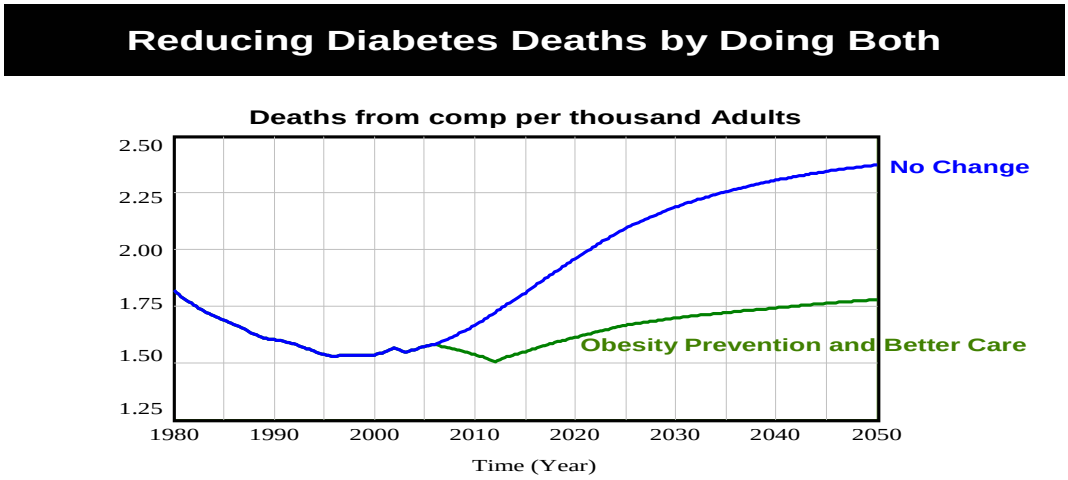


Figure 3

[13] Sources: Vermont Department of Health; Centers for Disease Control Diabetes Systems Modeling Project, 2005. (unpublished)

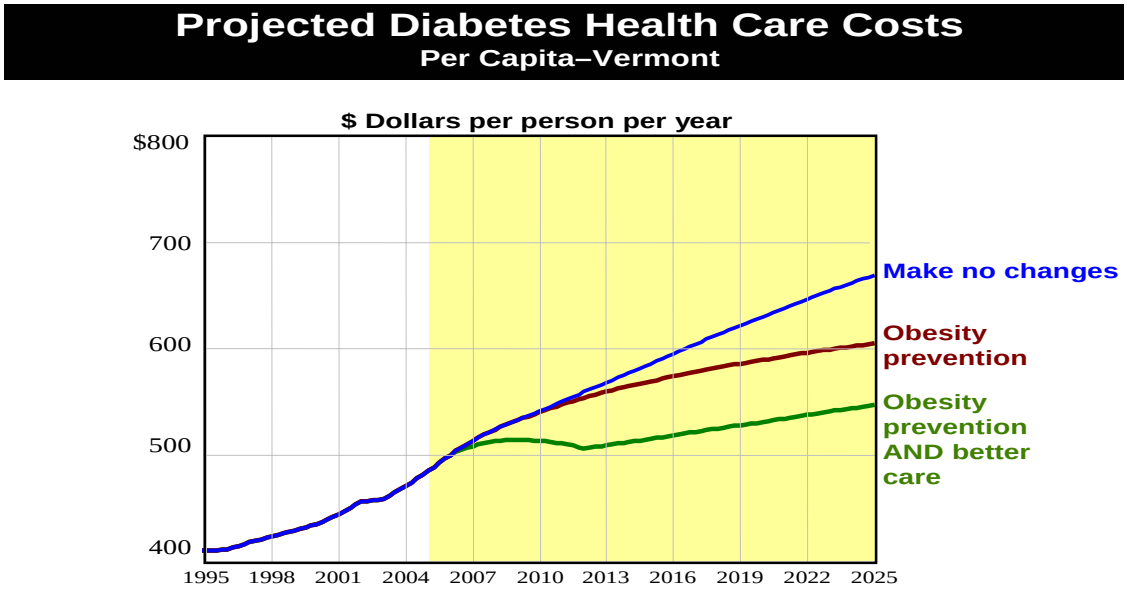

Projected Diabetes Health Care Costs
Per Capita–Vermont
$ Dollars per person per year
$800
700
600
500
400
1995
1998
2001
2004
2007
2010
2013
2016
2019
2022
2025
Make no changes
Obesity prevention
Obesity prevention AND better care

Figure 4

B. The Blueprint Model

The Chronic Care Model has undergone some modification for implementation at the system-wide and statewide levels in Vermont. The major differences between the Chronic Care Model and the Blueprint include:

Self-Management Support – The Chronic Care Model looks primarily to the health care organization as the resource to assist patients in gaining the knowledge and skills to manage their own health care. In the Blueprint, the role of the organization/provider to assist patients will be supported throughout the state by community-based strategies that expand the scope of services and integrate them with other broad-based community interventions to help individuals in becoming self-managers of their care.

Health Care Organization/Prepared, Proactive Health Team – In both models, the bulk of the work of change falls to the individual provider and practice team. In a managed care setting, much of this burden can be reassigned to or shared with other parts of the organization. The primary difference for Vermont practices is that there is no place to shift that burden, so it becomes incumbent on the Blueprint and the Health Systems sector to devise strategies to cover financial and administrative costs of adopting new office systems, decision support tools, and information systems.

Community Resources and Policies – In the Chronic Care Model, the provider team is expected to be aware of services available in the community and make referrals as needed. This is a burdensome process for most providers and does not address the need to develop those services in the first place. Through the Blueprint, communities will receive financial and technical support to develop services that make the community as a whole a healthier place to live and to offer specific services that support self-management and healthy behaviors among people with chronic conditions, and to link these back to the provider practices. Utilization of the Vermont 211[14] system will further support provider and consumer access to these resources.

Information Systems – Two factors require a different approach to clinical information systems in Vermont than envisioned in the Chronic Care Model. Vermont practitioners must integrate data from multiple disparate sources into their information systems, making it a more complex undertaking than in a managed care setting. In addition, federal and state policy not only demand increasing accountability but also supports the development of comprehensive health information systems. The Blueprint approach therefore must be aligned with the Regional Health Information Organization (RHIO) being developed in Vermont by the consortium of Vermont Health Information Leaders (VITL.)

[14] Vermont 2-1-1, a program of United Ways of Vermont, is a health and human services information and referral program serving the state.

Health System Design – In both the Chronic Care Model and the Blueprint, the critical role of the "system" to support high quality care is central. However, unlike the managed care setting for which the Chronic Care Model was developed, Vermont provider practices work with many different systems and health plans. Hence, much of the Blueprint work must involve significant collaboration among traditional competitors to facilitate agreement on decision support guidelines, clinical information systems, and to support design of new delivery and reimbursement structures.

Delivery System Design and Decision Support – In the Chronic Care Model, these necessities are identified as separate components of the model. In the Blueprint, both are incorporated in strategies developed for health systems, provider practice, and information systems.

C. Vermont Department of Health Obesity Prevention Program

As seen in the preceding figures, prevention of obesity has a profound impact on reducing mortality from diabetes and associated costs. While the Blueprint focuses primarily on improving care, the Vermont Department of Health Obesity Prevention Program will be the primary means for developing prevention strategies. The strategic plan for the Obesity Prevention Program will be available by late 2005. Staff from the Program guided the development of standards for the community walking programs for the Blueprint and will do the same for nutrition and other services that share prevention and care components. Diabetes Prevention and Control Program staff collaborates closely with staff from the Obesity Prevention Program.

D. Implementation and Staged Roll-Out

Using the Chronic Care Model as a framework, the Blueprint's strategic approach will be implemented on two levels through coordinated activation of work plans for each of the work groups:

1. *Statewide initiatives* to plan and build consensus among stakeholders, identify best practices, build the infrastructure to support a redesigned system of care, and align incentives for sustainability.

2. *Community-focused initiatives* to support changes in approach to chronic care delivery with provider practices, consumer self-management, community activation and support systems, and information technology. Each of these efforts, as well as the synergistic effect of concurrent implementation, will be evaluated at the local Hospital Service Area (HSA) level.

Implementation will "start small" with an initial focus in Year 1 on a single chronic condition—diabetes.

Initial implementation of the Blueprint will focus on community-based pilots in two Hospital Service Areas (HSAs)--Bennington and St. Johnsbury. The St. Johnsbury

HSA comprises communities served by Northeast Vermont Regional Hospital. The Bennington County HSA comprises communities served by Southwestern Vermont Medical Center.

The initial pilot communities, defined as Hospital Service Areas (HSAs), were selected based upon the following criteria:

- Clinical need (based on hospital discharge data for diabetes).
- Hospital leadership.
- Information technology capacity and readiness (connectivity between hospital and physician practices).
- Community readiness (proactive providers, early adopters of the Chronic Care Model, demonstrated community activation and support).
- Engagement in the Blueprint (demonstrated by Steering Committee and/or Workgroup representation).

As the model is refined, the Blueprint will spread incrementally over five years to include new chronic diseases and to encompass every HSA in the state through staged implementation. The pace of the implementation will be determined by information gained from pilot communities in Year 1 to assure spread of "best practice" as well as by the availability of funds to support engagement of all HSAs over the next five years.

In addition to the Blueprint community pilots, a number of related initiatives whose efforts are aligned with the Blueprint are underway in Vermont:

- As part of the VAHHS IHI Impact Project, several hospitals will address practice redesign in 2006 consistent with the Blueprint goals for their physician practices, with a focus on access and planned care. Hospitals will include Porter Medical Center, North Country Hospital and Mt. Ascutney Health Center.
- Clinical academic medical center researchers at the University of Vermont are using a data base management system called the Vermont Diabetes Information System (VDIS) to assist in diabetic care management. The Department of Health Diabetes Program and the Blueprint collaborate with these researchers regarding strategies for improving and systematizing ambulatory clinical practices and clinical outcomes for diabetes.
- Springfield Hospital, with assistance from VPQHC, has implemented components of the Chronic Care Model and is testing a new training approach known as the "collaborative on wheels" for their local providers.
- Vermont Information Technology Leaders (VITL) is working on pilot efforts that will lead to eventual development of a RHIO (Regional Health Information Organization). The Blueprint IT strategy must align with this effort. Collaboration and coordination are underway to assure a common approach to standards and architecture to support both strategic efforts, with the eventual goal of a common governance structure.
- The Vermont's National Governors Academy (NGA) team working on Chronic Disease management, led by OVHA, is aligned with the Blueprint goals. Resources made available by the NGA will help support development

and implementation of an all payer claims data base, which is a requirement of the 2005 legislative session.

- OVHA and the Vermont Department of Disabilities, Aging and Independent Living, with funding from the Centers for Medicare and Medicaid Services (CMS), are developing a model for integrating acute and primary care with long term care for frail elders and adults with physical disabilities, using consumer-centered interdisciplinary teams. Efforts to respond to the specific needs of these populations must be aligned with the Blueprint chronic care goals.

E. Evaluation

All components of the Blueprint will be evaluated. In the section on Goals and Objectives that follows, more than 30 measures of progress, organized by focus area, are identified. Additional measures will be found in the work plans of each of the five work groups.

The Blueprint Executive Committee recognizes that the goals of the Strategic Plan are aggressive and that successful execution of the plan relies on effective statewide and local partnerships, local engagement, and voluntary participation. Subsequently, the Strategic Plan will be reviewed every six months to evaluate progress on goals and objectives and to identify any barriers to implementation. Lessons learned will guide execution, with plan modifications based on assessment.

Better care should result from an improved system of care in which providers use the concepts and tools of the Chronic Care Model. This can be measured using available data on common indicators of compliance with evidence-based performance standards. Increasing the number of people receiving care will increase the proportion of the population that can receive those improved services. Separately and together, the self-management programs and community walking programs should enhance and support self-care. Self-management can be measured using common indicators of disease control including laboratory values, results of clinical examinations, and other data. However, these measures currently are not available in a systematic way. HEDIS[15] measures apply only to the sub-set of the population whose health plans are required to collect data and laboratory reports for certain conditions. Most measures can be found only in charts in physician offices.

Phase I of the Information Technology Strategy for development of a Chronic Care Information System (CCIS) included funding for development of the VPQHC registry known as the Vermont Health Record. The registry provides another tool to assist in evaluative data analysis, as population-based reports will be available to track changes in clinical outcomes resulting from concurrent implementation of all components of the Chronic Care Model.

[15] HEDIS is Health Plan Employer Data and Information Set®

Finally, the result of these improved measures of health should lead to the long term impacts that have been identified as goals of the Blueprint: improved clinical status, improved functional status, and moderated costs. Mortality, hospital discharge, and health system utilization data are all available to measure improvements in clinical status. Limited data from BRFSS is available to monitor indicators of physical and mental health, although this should be supplemented with more robust indicators if possible. Methods for monitoring costs are also in need of further development. At this time, data are limited to hospital discharge charges. This must be expanded to include the payment experience of health plans. As a result of legislation passed in 2005, BISHCA will begin to receive carrier claims data, which will provide another source of non-individually identifiable data for population based evaluation and tracking.

A logic model is a planning tool that provides a visual representation of plans for a project and serves as a guide to appropriate evaluation. A simplified logic model designed for evaluating the Blueprint can be found at Appendix B.

Studies have demonstrated improvement in health status measures using interventions that are consistent with components of the Chronic Care Model, either singly or in combination. The Blueprint will test and evaluate the interventions that are implemented in Vermont for all components of the Chronic Care Model. One approach is the Model for Improvement,[16] which utilizes a systematic approach to improving health care processes and outcomes:

1. Setting time-specific and measurable aims.
2. Identifying changes that are most likely to result in improvement.
3. Using quantitative measures to determine if a specific change actually leads to an improvement.
4. Using the Plan-Do-Study-Act (PDSA) cycle to test change on a small scale in real settings by planning it, trying it, observing the results, and acting on what is learned.
5. Learning from each small-scale test and refining the change through repeated PDSA cycles.
6. Implementing the change on a broader scale incrementally, ultimately spreading the change on a wide scale.

VI. Barriers to Implementation

Implementing the Blueprint will provide numerous challenges. Some barriers to implementation include:

Provider Practice – Because many primary practices already experience financial challenges, they may be averse to risk or change, particularly if the change has an associated cost in time or resources. Reimbursement structures and rates that vary among payers as well as prior authorization procedures further complicate the providers' ability

[16] The Model for Improvement was developed by Associates in Process Improvement and is promoted by the Institute for Health Improvement (IHI). www.ihi.org

to apply uniform approaches to the treatment and management of the same condition. Because panel sizes in some practices may be too small to benefit from incentives provided by individual carriers, cooperation for establishing common clinical guidelines and evaluation metrics is critical to drive and sustain required changes. Further, the diversity of practice types throughout the state (academic vs. private, single vs. group, rural vs. 'urban') poses challenges in approach. This, in turn, affects costs as well as sustainability of the implementation strategy. Reimbursement for group, telephone, or e-visits will need to be evaluated and CMS[17] will need to be a key partner in long term system changes.

Self-Management – Various disease-specific education programs are in place to assist patients in managing their health. However, these generally do not address the self-empowerment and behavior change skills required for effective long term disease management. While both approaches are critical, providers and patients need to understand the differences and benefits of each in determining the best program for the patient's immediate and long term need. While self-management programs that utilize a licensed professional as faculty generally are covered by the insurance carrier (e.g., American Diabetes Association-recognized diabetes education program), programs that utilize lay faculty are not uniformly reimbursed. The Healthier Living Workshop adopted by the Blueprint utilizes lay faculty with chronic conditions as peer educators. ADA educators have also expressed concern that the Healthier Living Workshop may decrease enrollment in their diabetes education classes, versus the program being a source of referral. Appropriate education and outreach, as well as carrier recognition and reimbursement of this evidence-based program will be significant factors for long term sustainability.

Community Activation and Support – Most community resources are not linked to the health care delivery system. Provider practices often are unaware of local community resources or gaps in services for their patients. Yet individuals are most likely to take action for improved health (e.g., physical activity, smoking cessation, weight loss) when they are directed by their health care providers and when they feel supported in their efforts. Transportation as well as the costs associated with some of these efforts pose additional barriers to engagement and sustained change for individuals.
In the absence of a community culture that makes physical activity the norm, the availability of resources in the community is not enough to motivate behavior change among individuals who have been sedentary for most of their lives, and who are among those at highest risk for chronic disease as a result.

Information Technology – Information technology is a key component of the Chronic Care Model. However, not all provider practices are computerized, nor are all staff computer literate. Many rural practices lack high-speed Internet access. Dial-up Internet access is neither adequate to meet provider needs nor to satisfy Blueprint goals for automatic data feeds into an electronic health record or registry. The cost of information technology solutions, including hardware, software, and technical expertise, are significant. Further, information technology standards and architecture considerations

[17] Centers for Medicare and Medicaid Services

must align with other statewide health information technology efforts (i.e. VITL). Non-technical issues including governance, confidentiality, security, and management of information on Vermonters who seek care in bordering states, also pose significant challenges.

VII. Financing

The Blueprint aims to change the way health care is delivered. In the long run, sustainability of the Blueprint will depend on several interrelated factors.

There is ample evidence that programs that address individual components of the Chronic Care Model can improve health and reduce costs.[18,19,20,21,22,23,24,25] Furthermore, the CDC Diabetes System Model predicts lower costs to the system overall by providing better care (*See* Figure 4). When the return on investment becomes positive, attention and commitment to sustaining the Blueprint will undoubtedly gain momentum.

Substantial investment in the infrastructure will be required to achieve and maintain change on a statewide level. Those infrastructure changes for all focus areas are contained within this plan. This investment must come from state government, Vermont health plans, and other components of the health care system. It is also critical that the federal Medicare program participate. State financing is essential for start-up costs for the Blueprint as a whole, and for long term support for community-based services and a portion of self-management services. Long term sustainability will be dependent on the willingness of health plans, including Medicare and Medicaid, to realign payment systems to reward quality, encourage early intervention, and reduce use of duplicative, unnecessary and costly services.

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VIII. Strategic Plan: Goals and Objectives

A. Overarching Goals for the Blueprint

Goal A.1 The quality of care for Vermonters with chronic conditions will improve.

Goal A.2 The quality of life for Vermonters with chronic conditions will improve.

Goal A.3 The cost of caring for Vermonters with chronic conditions will moderate.

B. Goals and Objectives for Replication and Spread of the Blueprint Statewide

Goal B.1 By 2010, the Blueprint will be implemented in 75 percent of primary care practices in each HSA.

Objectives:

B.1.1 In 2005-06, initiate pilots in Bennington and St. Johnsbury with an initial focus on diabetes.

B.1.2 By February 2006, establish criteria for selecting new communities/HSAs.

B.1.3 From 2007- 2010, add new communities/HSAs annually until the Blueprint is implemented in all HSAs.

Goal B.2 By 2010, the Blueprint will be inclusive of no fewer than four chronic conditions.

Objectives:

B.2.1 By January 2006, establish criteria for selecting additional chronic conditions.

B.2.2 From 2007 – 2010, expand application of the Blueprint to management of other chronic conditions in each community one year after initiation of diabetes efforts (i.e., Year 2 of implementation in each new community/HSA).

B.2.3 By June 2006, recommend educational approaches for implementation of the Blueprint in provider practices.

C. Overarching Goals and Objectives Specific to Diabetes

Goal C.1 The quality of care for individuals with or at risk for diabetes will improve.

Objective:

C.1.1 By 2010, reduce the mortality rate among individuals with diabetes by 6 percent to 19.4/1000 individuals with diabetes.

Goal C.2 The quality of life for individuals with diabetes will improve.

Objectives:

C.2.1 By 2010, improve the physical health of individuals with diabetes in care so that, on average, 26.7 days per month they rate their physical health as "good" or "better."

C.2.2 By 2010, improve the mental health of individuals with diabetes in care so that, on average, 26.9 days per month they rate their mental health as "good" or "better."

Goal C.3 The cost of health care for individuals with diabetes will moderate as a result of implementing the Blueprint statewide.

Objective:

C.3.1 By 2010, reduce the hospital discharge rate for individuals with diabetes by 5 percent to no more than 320/1,000 individuals with diabetes.

Goal C.4 Access to health care by individuals with diabetes will improve.

Objective:

C.4.1 By 2010, increase the proportion of individuals with diabetes who are in care to 88 percent.

D. Goals and Objectives for Provider Practice

Problem Statement: The current acute care model is poorly adapted to the needs of individuals with chronic illnesses. This can lead to inefficiency, fragmentation, and additional cost to both the patient and the health system. Few provider practices in Vermont currently are aware of or utilize the framework of the Chronic Care Model to care for their patients with chronic illness. In the absence of a clear communication plan and financial incentives to participate in the Blueprint, provider engagement will be a challenge.

Goal D.1: The proportion of patients receiving care consistent with evidence-based standards will increase.

Objectives:

D.1.1 By 2010, increase the proportion of individuals with diabetes in care whose HbA1c and LDL values are within the goal range. By December 2005, the Provider Practice Work Group, in consultation with the Information Technology Work Group, will identify data source(s) to establish baselines, set targets, and document laboratory indicators of improvement for this objective.

D.1.2 By 2010, ensure that 75 percent of primary care providers are using the Vermont Health Record[26] or a tool with equivalent functionality for proactive individual and population-based care management.

D.1.3 By 2010, increase to 95 percent the proportion of individuals with diabetes in care who report 2 or more HbA1c tests in the past 12 months.

D.1.4 By 2010, increase to 93 percent the proportion of individuals with diabetes in care who report having a dilated eye examination within the past 12 months.

D.1.5 By 2010, increase to 73 percent the proportion of individuals with diabetes in care who report having had an influenza immunization within the past 12 months.

An initial work plan for accomplishing these goals and objectives is available at http://www.healthyvermonters.info/hi/chronic/blueprint-MDworkplan.pdf

E. Goals and Objectives for Patient Self-Management

Problem Statement: Vermonters with chronic conditions spend most of their time functioning outside the health care system, in their homes or workplaces. Self-management is the cornerstone of day-to-day care for all chronic conditions. Good self-managers can be cultivated through appropriate services and programs. While there are self-management programs in Vermont for selected conditions, these programs are not applicable to multiple conditions, nor do they address essential personal action and care planning, problem solving, or coping skills.

Goal E.1: Vermonters with chronic conditions will be effective managers of their own health.

Objectives:

E.1.1 By 2010, schedule the Healthier Living Workshop[27] no less than 4 times per year in each of the HSAs with no fewer than 75 sessions offered statewide.

E.1.2 In each year the Healthier Living Workshop is offered in a HSA, achieve an average group size of 12 participants, 6 of whom have a diagnosis of diabetes.

E.1.3 By 2010, ensure that at one year follow-up, 85 percent of participants in the Healthier Living Workshop report agreement with the statement: "I have been able to maintain the lifestyle changes I have made for my health condition."

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[26] The Vermont Health Records is an electronic registry of data for individual and population-based care management that has been developed by the Vermont program for Quality in Health Care, with funding from the Blueprint.

[27] The Healthier Living Workshop is the same used in Vermont for the Stanford University Chronic Disease Self-Management Program. .http://patienteducation.stanford.edu/programs.cdsmp.html

An initial work plan for accomplishing these goals and objectives is available at http://www.healthyvermonters.info/hi/chronic/blueprint-SMworkplan.pdf

F. Goals and Objectives for Community Activation and Support

Problem Statement: Physical inactivity and obesity are risk factors for many chronic diseases and are among the leading "real" causes of mortality. To motivate sedentary individuals to change long-established behaviors, communities will need to create cultures in which being physically active are the norm for the majority rather than the pursuit of a few. There are few communities in Vermont in which citizens, health professionals, businesses, and public and private organizations engage in effective partnerships to promote the health of all community members. Community programs and resources are not well linked to the health care delivery system. Provider practices are often unaware of local community resources for their patients who are in need of referrals.

Goal F.1: Vermonters will live in communities that support healthy lifestyles and offer opportunities to prevent and manage chronic conditions.

Objectives:

F.1.1 By 2010, ensure that each city and town with a population of 2,000 or more has in place a walking program for adults with, or at risk for, chronic conditions.

F.1.2 By 2010, increase to 45 percent the proportion of individuals with diabetes in care who exercise at least 30 minutes per day, 5 days per week (or 20 minutes of vigorous activity at least 3 time per week) and to 79 percent the proportion who exercise at least 15 minutes per day, 5 days per week.

F.1.3 By 2010, halt the increase in the proportion of adults who are obese[28] at 22 percent.[29]

[28] Obesity is defined as a Body Mass Index (BMI) of 30 or more as calculated from weight and height in self-reports to BRFSS.

[29] The prevalence of obesity can be expected to increase before the impact of changes in caloric consumption and physical activity can be fully implemented. Starting from a baseline of 19 percent in 2003, a longer term goal is to reduce the proportion of people who are obese to 15 percent of adults by 2015.

An initial work plan for accomplishing these goals and objectives is available at http://www.healthyvermonters.info/hi/chronic/blueprint-community-workplan.pdf

G. Goals and Objectives for Information Technology

Problem statement: To provide effective care, health care providers need clinical and demographic data to monitor patient needs and support clinical decisions. Provider practices do not routinely have access to information systems that support proactive, planned care for their patients with chronic conditions. Information systems are not routinely integrated and aligned to facilitate sharing of data sources. Confidentiality and security requirements pose significant challenges to developing secure data exchanges between provider practices as well as with laboratories, insurers, hospitals, and pharmacies.

Goal G.1: Vermont will have a Chronic Care Information System (CCIS) that supports statewide implementation of the Blueprint for both individual and population-based care management.

Objectives:

G.1.1 By 2010, ensure that the Vermont Health Record or a tool with equivalent functionality for proactive individual and population-based care management is operational in at least 75 percent of primary care practices.

G.1.2 By July, 2006 ensure that policies and processes that guarantee the security and privacy of individual health information, in alignment with Vermont Information Technology Leaders (VITL), are in place.

G.1.3 By July, 2006 complete testing of the Vermont Health Record individual and population-based reporting system in pilot communities.

G.1.4 By December, 2006 in Bennington and St. Johnsbury, and by 2008 statewide, ensure that automated lab data feeds to the Vermont Health Record are operational.

G.1.5 By December, 2006, link Healthier Living Workshop class participant data from pilot communities to the Vermont Health Record.

An initial work plan for accomplishing these goals and objectives is available at http://www.healthyvermonters.info/hi/chronic/blueprint-ITworkplan.pdf

H. Goals and Objectives for Health System Design

Problem Statement: The existing health care "system" is not, in fact, a system. The various stakeholders focus on different health indicators, have divergent priorities, and have different reimbursement structures. Existing mechanisms for promoting systems change and for rewarding improved performance are inadequate for the enormity of the task. As a result, health care providers face significant challenges to establishing a common approach to managing care for individuals with chronic conditions, adopting changes to office systems, and integrating information systems.

Goal H.1: Vermonters will be served by a health care system that invests in and recognizes quality.

Objectives:

H.1.1 By October 2005, convene a Health System Work Group to address sustainability of the elements of the Blueprint.

H.1.2 By December 2005, adopt a work plan developed by the Health System Work Group that identifies goals, objectives, activities, and timelines in at least these six priority areas:

- Common performance metrics.
- Developing the financing mechanisms necessary to achieve the goals and objectives of the Blueprint.
- Covering the costs of patient education.
- Pay-for-performance.
- Clinical guidelines for chronic conditions
- An integrated 'systems' approach at the pilot community level
- Others to be determined by the work group.

H.1.3 By 2010, adopt clinical practice guidelines for at least four chronic conditions.

I. Goals and Objectives for the Blueprint Organizational Structure

As part of the strategic planning process, the Blueprint Executive Committee clarified roles, responsibilities, and reporting authority for the components of its governance structure. To carry out the work of the Blueprint, an equally well-defined operational structure is needed

Goal I.1 The Blueprint will have an organizational structure that has the capacity to implement and sustain its goals, objectives, and work plans on the statewide and community levels.

Objective:

I.1 By March 2006, develop an organizational framework for implementation of goals, objectives, and work plans on the statewide and community levels.

J. Goals and Objectives for Effective Communication

In the course of the strategic planning process, effective communication was identified as critical to the success of the Blueprint. A communication plan is needed within the Blueprint's organizational structure to manage the flow of a tremendous volume of information and to share information efficiently and effectively among all levels of the organizational structure. A strategy is also required for "marketing" and presenting clear and consistent messages about the Blueprint to stakeholders and the public.

Goal J.1: Communication will be effective and timely at all levels of the organizational structure to support planning, implementation, and evaluation of Blueprint goals and objectives.

Objective:

J.1.1 By December 2005, develop and implement a plan that will facilitate and support effective communication within and between all levels of the Blueprint partnership, including management, advisory, work group, community, and staff.

Goal J.2 Stakeholders and the public will have a clear understanding of the Blueprint.

Objective:

J.2.1 By December 2005, develop and implement a plan for communicating clear and consistent messages about the Blueprint and its implementation to stakeholders and the public.

K. Goals and Objectives for Evaluation of the Blueprint

Some indicators have been developed to measure progress on goals and objectives on the statewide level. For the most part, these indicators look toward outcomes in the year 2010. These indicators, along with baseline measures and data sources for evaluation, can be found in the document Directory of Objectives/Indicators.[30] The Directory includes indicators for the Vermont Department of Health Diabetes Prevention and Control Program and the Obesity Prevention Program, as well as for the Blueprint.

An evaluation plan is needed for measuring progress on both short- and long-term indicators for statewide and community initiatives, as well for evaluation of the effectiveness of the Blueprint's public-private partnership. In light of the ambitious

[30] Vermont Department of Health, August 21, 2005

nature of the goals of the Strategic Plan and its reliance upon statewide and local partnerships, local engagement, and voluntary participation, a review of progress on goals and objectives will be required every six months.

Goal K.1: A plan for evaluating progress on all aspects of the Blueprint will be in place to guide in measuring progress toward achieving process and outcome objectives at the statewide and community levels.

Objectives:

K.1.1 By January 2006, develop and implement a plan for monitoring and evaluating progress on programmatic goals and objectives.

K.1.2 By January 2006, develop and implement a plan for monitoring and evaluating the effectiveness of the Blueprint's public-private private partnership and organizational structure.

IX. Appendices

A. Glossary of Acronyms and Terms

B. Blueprint Logic Model

C. Executive Committee members

D. Steering Committee members

E. Blueprint Partner Organizations

F. Work Group members/co-chairs

G. Vermont Department of Health Blueprint Staff

Appendix A: Glossary of Acronyms and Terms

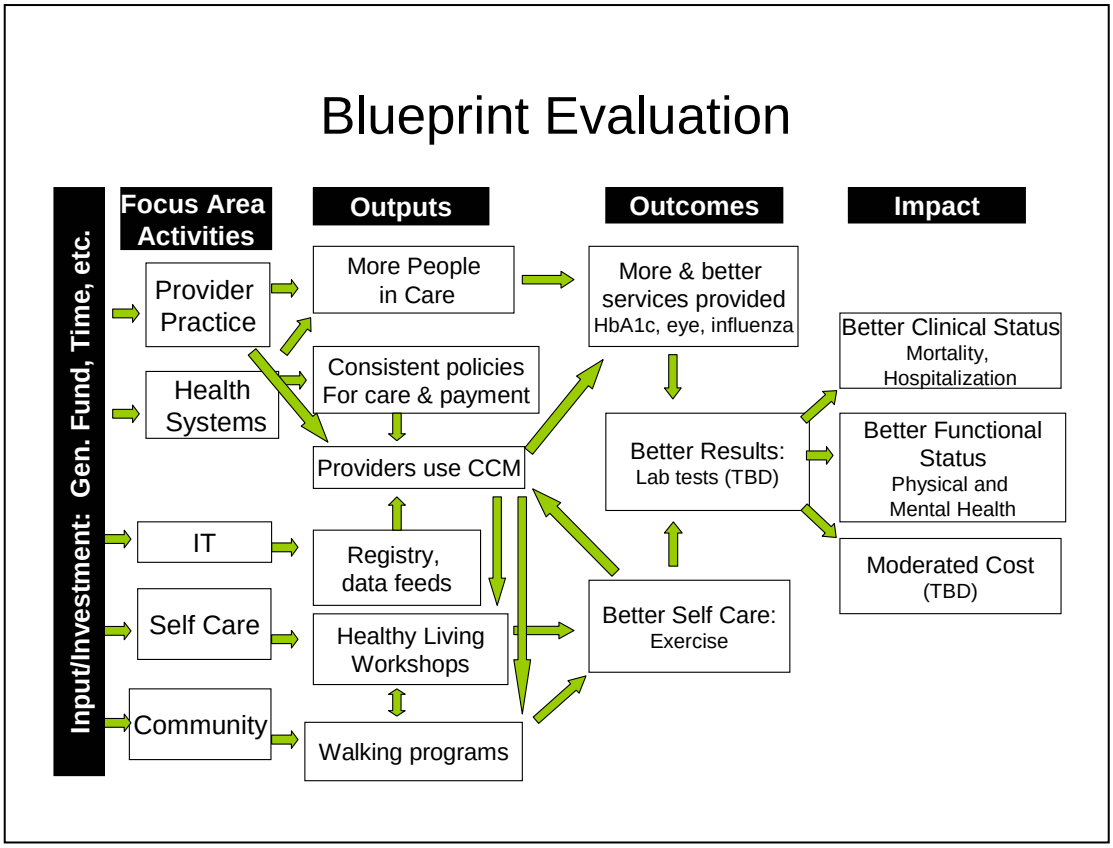
BISHCA	Vermont Department of Banking, Insurance, Securities and Health Care Administration
BRFSS	Behavioral Risk Factor Surveillance Survey
CCIS	Chronic Care Information System
Chronic Care Model	A national model for collaborative care and quality improvement that illustrates the components necessary to improve care for people with chronic conditions within a health care setting.
Chronic condition	Chronic illnesses and impairments that are expected to last a year or more, limit what the individual is able to do, and/or require ongoing medical care.
CDC	Centers for Disease Control
CMS	Centers for Medicare and Medicaid Services
Healthier Living Workshop	The name used in Vermont for the Stanford University Chronic Disease Self-Management Program
HEDIS	Health Plan Employer Data and Information Set®
HSA	Hospital Service Area. Regions representing local health care markets, as defined by the Vermont Dept. of Health. Some HSAs have more than one hospital.
IHI	Institute for Health Improvement
Logic model	A planning tool that provides a visual representation of plans for a project and serves as a guide to appropriate evaluation.
OVHA	Office of Vermont Health Access (Medicaid)
PDSA	Plan-Do-Study-Act
RHIO	Regional Health Information Organization
VCHIP	Vermont Child Health Improvement Program
VDH	Vermont Department of Health
Vermont Health Record	An electronic registry for individual and population-based care management.
VITL	Vermont Information Technology Leaders
VPQHC	Vermont Program for Quality in Health Care

Appendix B: Blueprint Logic Model

A logic model is a planning tool that provides a visual representation of plans for a project and serves as a guide to appropriate evaluation. Read from left to right, a logic model follows a progression from inputs (investments) that lead to strategies or activities. Those strategies in turn lead to outputs (products) which, if done well, lead to specified outcomes. Outcomes may be short or long term and are critical to achieving the ultimate long term impact (goal) that is desired. A logic model may also be read from right to left.

A simplified logic model for evaluating the Blueprint is shown below. The reality of Blueprint implementation and the relationships between components is actually far more complicated than depicted here. In this model, the investments lead to activities in each of the five focus areas. Outputs resulting from the activities of one or more of the work groups lead to more people in care and improved systems of care (common decision support materials, redesigned office systems, information systems). Outputs for the Self-Management focus area include the availability of self-management courses statewide. Outputs for the Community focus area include walking programs throughout the state. Each of these processes or outputs can be accounted for using standard narrative reports and/or data systems.

Blueprint Logic Model



Appendix C: Executive Committee Members

- Bea Grause (Executive Director, VT Association of Hospitals & Health Systems)
- Don George (Blue Cross Blue Shield of Vermont)
- Helen Riehle (VT Program for Quality in Health Care)
- Jim Hester (MVP Health Care)
- Joshua Slen, Director (Office of Vermont Health Access)
- Paul Harrington (Vermont Medical Society)
- Paul Jarris, Commissioner (Vermont Department of Health)
- Pat Jones, Acting Representative for BISHCA

Appendix D: Steering Committee Members

- Bea Grause, Executive Director (VT Association of Hospitals & Health Systems)
- Betty Rambur, Dean (UVM - College of Nursing & Health Sciences)
- David Reynolds (North Countries Health Care)
- Dian Kahn (BISCHA)
- Don George (Blue Cross/Blue Shield of Vermont)
- Greg Marchildon (AARP)
- Helen Riehle (VT Program for Quality in Health Care)
- Hunt Blair (Bi-State Primary Care, Montpelier)
- Jill Lord (Hitchcock/Vermont Organization of Nurse Leaders)
- Jim Hester (MVP)
- Joan Senecal (Dept. of Aging & Independent Living)
- John Evans (UVM - College of Medicine)
- Joshua Slen, Director (Office of Vermont Health Access)
- Judith Shaw (Vt. Child Health Improvement Program)
- Kathy Callaghan (Vt. Dept. of Personnel)
- Larry Ramunno (NE Health Care Quality Foundation)
- Laural Ruggles (NE Vt. Regional Hospital)
- Linda McIntire, Commissioner (Vt. Department of Personnel)
- Lisabeth Maloney, MD (Dartmouth Hitchcock Medical Center)
- Mark Novotny (Southwest Vermont Medical Center)
- Mimi Reardon, MD (UVM, College of Medicine)
- Norman Ward (Fletcher Allen Health Care)
- Pat Jones (BISHCA)
- Paul Harrington (Vermont Medical Society)
- Paul Jarris, Commissioner (Vt. Department of Health)
- Peter Cobb, Executive Director (Vermont Assembly of Home Health Agencies)
- Rich Tarrant (Vermont Business Roundtable/IDX)
- Rob Hockmuth (CIGNA)
- Robin Edelman (Vt. Department of Health)

Staff

- Eileen Girling (Vt. Department of Health)
- Ellen B. Thompson (Vt. Department of Health)

Appendix E: Blueprint Partner Organizations

AARP VT
Addison Cty Home Health & Hospice
Agency of Human Services
American Cancer Society
BISHCA
Bi-State Primary Care
Blue Cross/Blue Shield (BC/BS)
Bowse Health Trust-RRMC
Castleton Family Health
Centers for Disease Control & Prevention
Central VT Medical Center
Champlain Leadership Initiative
Champlain Senior Center
Chronic Conditions InfoNet
CIGNA Healthcare
Community Health Center
Copley Hospital
Dartmouth Medical School
Dartmouth-Hitchcock Medical Center
Dept. of Mental Health Services
Department of Aging & Independent Living
Dept. of Aging & Independent Living
DHMC, Lebanon
Rutland Regional Medical Center
Fletcher Allen Health Care (FAHC)
IDX/Vermont Business Roundtable
Lake Champlain Capital Management
MacColl Institute for Healthcare Innov.
MVP Health Care
NE Health Care Quality Foundation
NE VT Regional Hospital
NEVAAA (Northeastern VT Area Agency on Aging)
Northern Counties Healthcare
Northeastern VT Regional Hospital
Northwestern Medical Center
Office of VT Health Access (OVHA)
RehabGYM
Retired Seniors Volunteer Program (RSVP)
Riverside Life Enrichment Center
Rutland Regional Hospital
Senator Jeffords Office
Senator Leahy Office
Southwest Vermont Medical Center
UVM College of Medicine
School of Nursing and Allied Health Sciences
VCHIP
VT Assembly of Home Health Agencies
VT Assoc. of Hospitals & Health Sys (VAHHS).
VT Business Roundtable
VT Child Health Improvement Program
VT Department of Health
VT Department of Personnel
VT League of Cities & Towns
VT Lung Association
VT Medical Society
VT Organization of Nurse Leaders
VT Program for Quality in Health Care

Appendix F: Blueprint Workgroup Members/Co-Chairs

Self-Management

- **Robin Edelman – Chair (VDH)**
- **Sarah Narkewicz – Co-Chair (Bowse Health Trust-RRMC)**

- Abbey Reese (OVHA)
- Amy Nickerson (DAIL)
- Beth Kuhn (Champlain Initiative)
- Betty Rambur (UVM, School of Nursing)
- Connie Van Eeghen (Copley Hospital)
- Deborah Dameron (American Cancer Society)
- Dick Keane (VDH)
- Donna Cliff (NE Health Care Quality Foundation)
- Eileen Girling (VDH/Blueprint)
- Elizabeth Cote (UVM/AHEC)
- Frank Russell (OVHA)
- Jamie Balch (NW Medical Center)
- Jean McCandless (VDH/Arthritis Program)
- Jessa Block (VT Medical Society/Consumer)
- John Pierce (DDMHS)
- Laural Ruggles (NE VT Regional Hospital)
- Laurel Decher (VDH)
- Laurinda Poirier-Solomon (FAHC)
- Margo Caulfield (Chronic Conditions InfoNet)
- Marianne Ward (VDH/Health Improvement)
- Mary Wood (DHMC)
- Merle Taylor (NE Health Care Quality Foundation)
- Michael Hartman (CRT Director, Washington County)
- Patricia A. Launer (VPQHC)
- Ruth Ann Rhodes (Community Health Ctr., Burlington)
- Sharon Gutwin (RehabGYM)

Community

- **Joan Senecal – Chair (DAIL)**
- **Karen Garbarino Co-Chair (VDH)**

- Amy Nickerson (DAIL)
- Brendan Hogan (OVHA)
- Cathy Rousee (NKHS)
- Celine M. Coon (Consumer Rep)
- Darlene Ahrens (VDH/St. Johnsbury District Office)
- David Baker (Project Director, CDC Disability and Health Promotion Grant)
- Debbie Dameron (Am. Cancer Society)
- Eileen Girling (VDH/Blueprint)
- Heidi Joyce (Vt. League of Cities and Towns)
- Jenny Patoine (NEVAAA)
- Larry Goetschius (Home Health)
- Linda Berlin (UVM Extension Service)
- Linda Shaw, RN, Community Outreach Manager, Copley Hospital
- Loretta Nelson (Riverside Life Enrichment Center)
- Michele Leno (Central VT Hospital)
- Nan Hart (RSVP)
- Pam Farnham (FAHC Community Wellness)
- Phil McCollough (Provider Rep)
- Rebecca Ryan (VT Lung Association)
- Robin Edelman (VDH/Diabetes Program)
- Robin Girr (Community Member)
- Russell Frank (Office of Vermont Health Access)
- Syndi Zook (Director, Champlain Senior Center)

Information Systems

- **Jim Hester – Chair (MVP)**
- **Mike Gagnon Co – Chair (FAHC IT)**

- Andrea Lott (St. Johnsbury /Northeastern VT Regional Hospital)
- Art Limacher (VDH/IT)
- Bill Apao (VDH, Health Surveillance)
- Craig Morton (Dartmouth/Hitchcock)
- Cy Jordan (VPQHC)
- Dian Kahn (BISHCA)
- Eileen Girling (VDH/Blueprint)
- Greg Farnum (VAHHS)
- Hunt Blair (Bi-State Primary Care, Montpelier)
- Judith Shaw ED, (VCHIP)
- Judy Higgins (AHS)
- Ken Hoeppner (Lamoille County Mental Health)
- Larry Ramunno, MD (NE Health Care Quality Foundation)
- Laurie Hurowitz (AHEC)
- Norm Ward, MD (FAHC)
- Paul Harrington (VT Medical Society)
- Rich Ogilvie (Southwest Medical Center)
- Rich Tarrant (IDX/Vermont Business Roundtable)
- Russ Davignon (Central Vt. Medical Center)

Provider Practice

- **Mark Novotny, MD – Co-Chair (Southwestern VMC)**
- **Donna Izor, Co-Chair (Ctrl. VT Medical Center)**

- Alison White (Dartmouth Hitchcock)
- Bradley Berryhill, M.D. (Castleton Family Health)
- Carol Vassar, MD (Provider Rep)
- Don George (BC/BS)
- Don Swartz, MD (VDH - Health Improvement)
- Eileen Girling RN, MPH (VDH/Blueprint)
- James Mauro (BC/BS)
- Jerry Salkowe, MD (Medical Director, MVP)
- John King, MD (Milton Family Practice)
- Judith Shaw ED, (VCHIP)
- Margaret Joyal (Washington County Mental Health)
- Mimi Reardon (University of Vermont, AHEC)
- Norm Ward, MD (FAHC)
- Paul Harrington (VT Medical Society)
- Phil Lapp, MD (Endocrine, Rutland Regional)
- Rob Penney, MD (Provider Rep)
- Robert Hockmuth, MD (CIGNA)
- Robert Schwartz, MD (PHIN)
- Russ Davignon (Central Vermont Medical Center)
- Scott Strenio (Medical Director OVHA)
- Simon Frishkoff, ND (Oberlin)
- Steven Boyce, Practice Manager,(DHMC, Lebanon)
- Steve Perkins (Medical Director, BC/BS)
- Tonya Howard, NP (Northern Counties Healthcare)
- Wendy Davis, MD (FAHC)

Consultants:

- Josh Slen, Director OVHA
- David Gorson, MD, (Southwestern VMC)

Health Systems Workgroup

- **Paul Harrington – Co-chair (Vermont Medical Society)**
- **Helen Riehle – Co-chair (VPQHC)**

- Barbara Walters (Dartmouth Hitchcock)
- Don George (BC/BS)
- Eileen Girling (VDH/Blueprint)
- Frank Provato, M.D. (Chief Medical Officer TVHP/BCBS)
- Greg Peters
- Jill Olson (VAHHS)
- Joan Haslett (DAIL)
- Kathy Callahan (Vt. Dept. of Personnel)
- Ken Deon (KPMG)
- Kevin Veller (VT Congressional Delegation)
- Lou McLaren (MVP)
- James Mauro (BC/BS)
- Pat Jones (BISHCA)
- Rob Hockmouth (CIGNA)
- Scott Strenio (Medical Director OVHA)
- Simon Rosenstein (Great-West)
- Stephen LeBlanc (Dartmouth Hitchcock)

Appendix G Vermont Department of Health Blueprint Staff

- Eileen Girling, Executive Director
- Art Limacher, Information Technology
- Jessica Porter, Operations Director
- Ellen Thompson, Planning Chief
- Vacant , IT Functional Leader
- Vacant, Community Functional Leader
- Vacant, Self Management Functional Leader
- Vacant, Provider Practice/Health System Functional Leader